Page 124

Q. Sure. And -- and assuming that -- let me just ask you to assume something for a second, that you didn't read her deposition; you're reading this note, "speech slow." What came to mind before you read her explanation?

A. Came to mind was that that might represent that the person was somehow obtunded, that there could be some type of neurological event going on.

Q. And would that be consistent with somebody who had a subarachnoid bleed?

A. Could be.

Q. When she says -- is it TMs bilaterally a bit cloudy, but mobile? What does that mean to you?

A. It means that she had -- actually, she's a pretty good practitioner. She took the time to actually insufflate the ears and not just jump to the conclusion that the person had ear infections.

Q. Okay. And in fact, she -- okay. And what does "a bit cloudy" mean?

A. It means that they just don't look absolutely sparkling clear. And so that, on the one hand, could be an inference that perhaps there's an early infection or something like that going on, but that she took the extra step and she insufflated the ears, found them to be mobile. And that is a good

Page 125

indication that the person doesn't have an ear infection.

Q. Is -- and I'm just trying to understand the "bit cloudy." Does that -- I mean, is that something that you would see when you insufflate?

A. No. Just from direct visualization.

Q. Okay. And then how about the -- that the neck was supple? What did you take from that?

A. I thought that was a -- a good thing to have done and that that meant that she was thinking about things, such as irritative meningeal events, such as infections or even subarachnoid hemorrhage.

Q. And does the -- the fact that the neck is supple, does that rule out a subarachnoid bleed?

A. No.

Q. Okay. Is there anything else that she -- I mean, is that how you would document, actually checking whether or not there was some meningeal irritation, just saying "neck supple"?

A. It's a good start. I mean, many people would write down Kernig and Brudzinski's sign as the classic, but I think it is, in my experience, very common for people to simply try to move the neck and see if it's mobile and then write that the neck is supple.

Page 126

Q. Okay. And then do you know whether or not this patient had any discomfort when she was checking his neck?

A. There's -- I took by inference that having a supple neck meant that there was no pain, but I see nothing here that says that he had no pain.

Q. All right. And was -- would that be something that you would be documenting, whether or not the patient had discomfort when you were checking their neck?

A. Honestly, I might write it just like that.

Q. As neck supple?

A. Yes.

Q. Okay.

A. But I might put non-tender.

Q. Do you have an understanding about whether or not this patient was looking for pain medications that morning?

A. I don't think he was.

Q. All right. You have gone through his -- I can tell from your report, you know, you looked back at -- at his records in terms of when he presented at the ANMC pri- -- previously. Is that correct?

A. Yes.

Q. All right. And do you have an

Page 127

understanding, as you sit here right now: When is the last time this patient actually presented to the emergency room at ANMC complaining of pain?

A. He infrequently came to the emergency department with pain.

Q. Okay. Well --

A. I can't -- I would have to have the record in front of me to actually pull up the -- because I get the clinic notes and the ER notes a little bit mixed up honestly.

Q. Okay. Well, is there a distinction to you between a patient presenting to -- to the emergency room and to a family medicine clinic?

A. Well, a lot of it's just convenience and timing, in terms of availability of access to the clinic. The -- and then the kind of symptoms they're having. So if now vomiting is the problem, then waiting for a day to get into the clinic may not be acceptable. If it's a "before hours kind of thing," if a person thinks they have something going on -- emergencies are self-defined of course.

Q. Sure.

A. So he self-defined himself as having an emergency, which is what we have people do.

Q. Does it -- does it affect your opinions at

Page 144

Q. At the morning that he presents at the Alaska Native Medical Center -- Center on April 19th, 2003, and if he presented with a headache going from the back of his head, going to the top of his head, would that be different than his presentation in the past, these prior visits that you have referred to to the family medical center or the family medical clinic or to the emergency room?

A. It seemed to be.

Q. Okay. If, in fact, that is how he presented that morning, would that change your opinion in this case?

A. No, it wouldn't change my opinion per se unless it -- if he perceived it as a significant change in his headache pattern.

Q. Okay. And that would -- that would be how you would -- that would affect your opinion in this case, if he thought it was different than the pain he had experienced in the past?

A. That radiation pattern by itself is very common for just myofascial-type pain that a person might have from radicular nerve roots, so there's -- that by itself would not raise the huge red flags.

Q. Okay.

Page 145

A. In the context of the patient describing it as something significant and different, that would definitely be something we would want to look into.

Q. Okay. Do you remember Donna Fearey testifying in her deposition that she didn't remember talking to him about whether or not the pain was different than what he had had before?

A. No, I don't remember that.

Q. Okay. Just one second. This is Donna Fearey's deposition at page 78. And I ask her: "Did you -- do you remember talking to him about whether or not this was pain that was different than what he had experienced before?"

"No, I don't remember."

And then I asked her: "Do you remember talking to him about whether or not this was the worst pain he had?"

"No."

Does that refresh your memory, or does that make any difference to you, that she just doesn't -- she didn't know whether or not --

A. No.

Q. She doesn't remember --

A. She --

Q. -- talking to him about -- that she doesn't

Page 146

remember talking to him about whether or not the pain was different than what he had experienced before?

A. Well, if she didn't ask those questions, and it sounds like she's not saying she didn't. She just doesn't remember.

If she didn't, I would prefer, and I think it would be -- the medical history should have that in it. She should have asked that. Now whether she did or she didn't I can really tell from that, but -- but I prefer she did ask those questions.

Q. Right. And that's not documented in the note from --

A. Correct.

Q. -- April 19th that she asked those questions. Is that correct?

A. No, it's not.

Q. All right. Would that be below the standard of care if she didn't ask those questions?

A. Those are questions that should be asked.

Q. And would it be below the standard of care if those questions were not asked?

A. Yeah, it would be. You should ask those questions when you're assessing the headache patient.

Page 147

Q. Okay. Do you have an opinion about whether or not Mr. Allen suffered a seizure in the afternoon of -- and you're smiling.

A. You know, he could have suffered a seizure.

Q. Okay. Do you -- are you going to render an opinion that it's more likely than not that he had a seizure or -- or that -- or do you know?

A. It's -- I definitely don't know. I can tell you that.

Q. Is this a subject that you have discussed with Mr. Guarino --

A. Yes.

Q. -- since the deposition of Dr. Mannix?

A. Yes.

Q. Do you know Dr. Mannix?

A. No.

Q. Okay. So is it possible that after talking to Mr. Guarino about the subject matter of a seizure, did -- did it come to your attention that the pre-hospital care report, paramedics had indicated that Mr. Allen's airway had emesis with blood?

A. No. I noticed that.

Q. You did notice that. And did -- and did you notice that they remarked that the HEENT was

Page 156

Q. He presents in the -- I'm sorry. He presents where? At the Alaska Native Medical Center emergency room?

A. When he -- it's going to be -- what we're going to talk about is his worst or his best by the time he actually is going to be matriculating into the system. His worst, in my opinion, is going to be probably a four.

Q. Did you talk to Mr. Guarino about this issue of when you look at a Hunt & Hess grade, whether or not it's when they first present to an emergency room or when it's, you know, later on?

A. We didn't discuss it per se, but we talked about that issue around and about. So we didn't have a big discussion about: Is it before or an after kind of thing, but we -- I think we both discovered, through some of our readings in your stuff, that -- that there were controversies about that.

Q. Okay. And controversies about when you look at the Hunt & Hess grade?

A. Yes.

Q. Okay. But is that something that you're qualified to talk about, whether or not -- how Hunt & Hess grades affect outcome?

Page 157

A. No.

Q. So your opinion -- go ahead.

A. No. I mean, that -- that's reasonable, what you say. I will leave it at that. That's fine.

Q. When you have somebody -- and you have dealt with patients with subarachnoid bleeds. If you determine that somebody has a subarachnoid bleed through a CT scan, is it below the standard of care then for you to just discharge that patient from the emergency room --

A. Yes.

Q. -- to go home?

A. Well, just to qualify, because I'll help you out here. There's subarachnoid hemorrhages, and there's subarachnoid hemorrhages. We discharge subarachnoid hemorrhages from the emergency department on the advice of the neurosurgeons when they're traumatic.

Q. I'm sorry. You discharge them from the emergency room --

A. From --

Q. -- to -- to the care of another health care provider. Is that right?

A. It --

Page 158

Q. No.

A. It can happen that a small subarachnoid hemorrhage from trauma will be discharged from the hospital, from the emergency department primarily.

Q. Okay. But that would be on the advice of a neurosurgeon?

A. Yes.

Q. Would you do that -- would you make that decision on your own?

A. No.

Q. Would that be fairly atypical?

A. To discharge somebody?

Q. To discharge a patient who has been diagnosed with a subarachnoid hemorrhage.

A. You know, my only point was that -- was just to focus the discussion on different types of subarachnoid bleeding, and those due to trauma are kind of a different animal than those due to other causes.

Q. Okay.

A. And so if we're foking -- focusing on the subarachnoid --

Q. Nontraumatic.

A. -- the nontraumatic subarachnoid hemorrhage, then absolutely it would be rather

Page 159

extraordinary for me to discharge somebody who I diagnosed as having a subarachnoid hemorrhage from the emergency department primarily.

Q. Is there an assumption, when somebody is diagnosed with a subarachnoid hemorrhage in the emergency room and that -- and they're fairly neurologically intact, is there an assumption that -- that that patient is going to undergo treatment?

A. Yes.

Q. Okay. And "treatment" meaning that their blood pressure would be monitored?

A. Yes.

Q. And that they would be -- their fluid intake would be monitored?

A. Yes.

Q. And that they may be provided medication, depending on what their situation is, that is, you know, whether or not they -- they're experiencing increased intracranial pressure?

A. Possibly. More -- more of it would be kind of pain management and different issues like that.

Q. Okay. And is that something that you have done in the emergency room setting; that is, you have been with a patient, I think as you described